DENTAL HEALTH

Indian Health Service

Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2000 Est. +/- 2000 Actual	2002 Est. +/- 2001
Dental Health					
Budget Authority	$80,062,000	$91,018,000	$95,305,000	+$15,243,000	+$4,287,000
FTE	745	763	781	+36	+18
Total Patients Treated	300,000	328,000	335,000	+35,000	+7,000
Total Services Provided	2,400,000	2,487,000	2,509,000	+109,000	+22,000

PURPOSE AND METHOD OF OPERATION

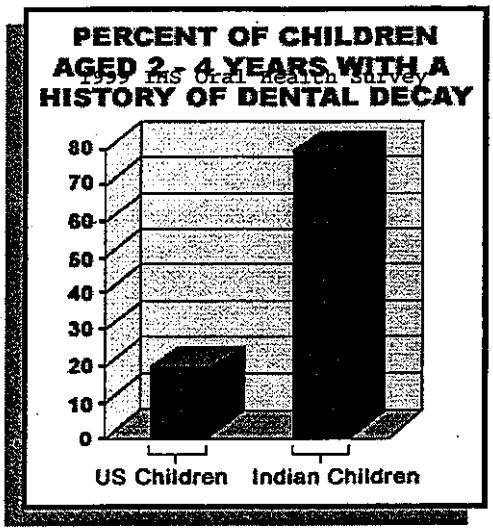
Program Mission and Responsibilities

The IHS Dental Program is committed to raising the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services at the community and clinic levels. Despite a history of documented improvements in oral health status, the oral health of Indian people still lags well behind that of the overall population and this disparity may be increasing. For the past two years oral health problems have been identified by consumers participating in budget formulation activities among the top priorities for funding enhancement. As a result, oral health has been identified as one of the IHS Director's initiatives for FY 2001.

Between the early 1970s and the early 1990s, a period of overall dental program expansion, the IHS Dental Program made significant strides in improving the oral health of the AI/AN population. Results of the IHS-wide Oral Health Status and Treatment Needs Survey of over 25,000 dental patients completed in 1991 revealed several important findings. When compared with results from earlier monitoring surveys, a general decline in tooth decay among children and adults was detected. This encouraging trend can be attributed mainly to the extensive commitment that the IHS and local communities have made to water fluoridation during the past decade and the expanded use of dental sealant. However, AI/ANs continue to have substantially higher rates of dental caries and periodontal disease than the U.S. population at large.

Indian people are affected by dental disease at rates 2 to 10 times that of the overal U.S. population; for Indian patients with diabetes the disaparity is even greater.

Currently, access to dental care at IHS is below full capacity because of a dental workforce crisis: approximately 22 percent of the dentist positions in the IHS are vacant.



A follow-up oral health survey was initiated in FY 1999 to determine the current oral health status and continued or emerging problems that must be addressed. Approximately 13,000 patients participated in the survey in all 12 Areas. A final report will be available in spring 2001.

The IHS has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so the basic services may be provided to more persons. Within the Schedule of Services, a service priority hierarchy used by the Dental Program, over 90 percent of services provided is basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community health promotion/disease prevention is essential to long-term improvement in the oral health of AI/ANs.

In 1992, the IHS added a full-time national coordinator for dental health promotion/disease prevention to provide technical assistance to IHS and tribal programs. Because of the significant loss of support of dental health promotion/disease prevention available at the Area level due to tribal contracting and vacanies, the national coordinator has attempted to develop alternative networks including local I/T/U dental staff to carry on essential dental health promotion and disease prevention activities.

Tribal programs continue to exert a growing influence in the management of oral health programs. The number of tribally managed programs continues to grow steadily. Staff employed by or providing care in tribal programs produce over a third of the total direct dental services. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. Tribal programs were well represented in the IHS 1991 Oral Health Survey of Indian patients and participated in the 1999 survey. Data gathered by these surveys provides tribes information from which to make rational decisions regarding their dental programs.

Best Practices/Industry Benchmarks

The IHS Dental Program has a long and distinguished history of serving as a benchmark of dental public health excellence. Beginning in the 1960s, the IHS Dental Program was a pioneer in developing dental resource planning

methods, and, in the early 1970's, published some of the first and most compelling findings regarding the efficiency and effectiveness of using expanded duty dental assistants in the provision of dental restorations.

Later in the 1970s, the IHS published what still remains as one of the most comprehensive and recognized approaches to quality assurance for dental care. In the 1980s and 1990s, the IHS Dental Program was recognized by winning three U.S. Public Health Service J.D. Lane research competitions for community based research/education projects as well as three American Dental Association awards for health promotion/disease prevention.

The program's Baby Bottle Tooth Decay Prevention Project, which won two of these awards, has been cited internationally as a model of community empowerment and program effectiveness. As part of these activities the IHS Dental Program collaborated with the World Health Organization, the Centers for Disease Control, the National Institutes of Health, the Head Start Bureau, and several universities.

But, undoubtedly, the ultimate benchmark of success for the public health organizations is what it accomplishes in term of positive outcomes for the people it serves. Based on analyses comparing findings from the most recent oral health survey completed in 2000, the results show, in comparison with the 1991 survey:

A **14 percent increase** in the number of children 5-19 years with no decay.

A **12 percent decrease** in the number of children 5-19 years with high decay rates (7 or more cavities).

A **21 percent increase** in the number of protective dental sealant placed on first and second molars in adolescent's ages 14 years.

A **9 percent increase** in the number of adults 35-44 years with periodontal disease (based on CPITN scores).

A **21 percent increase** in the number of adults 35-44 years who have never lost a tooth to periodontal (gum) disease or dental caries (cavities).

The Early Childhood Caries 5-year demonstration project will be evaluated in FY 01. The goals of this demonstration project are to reduce the percentage of young children with dental decay to 25 percent from baseline at each of the demonstration sites as well as to increase access to dental services by 25 percent at each site. Results of the demonstration will be shared program-wide in the summer of FY 2001.

ACCOMPLISHMENTS

The IHS dental program at Headquarters has been reorganized as the Division of Oral Health. Currently four professional and one administrative person comprise the staff that support a cadre of over 2500 dentists, dental assistants and hygienists in tribal and direct programs.

Specific accomplishments include:

- A workgroup has developed and is promoting clinical and community-based strategies to reduce the prevalence of early childhood decay. The strategies include providing a dental screening or exam by age one by medical and dental providers, teaching parents to brush their child's teeth and looking for early lesions that can be reversed with fluorides, and educating families about the disease process, diet and the importance of various fluorides.

- To reduce the prevalence of the dental decay, and increase access to care, a work group has developed a medical model of care that addresses dental decay as an infectious disease. Some of the key concepts are the importance of diagnosis of caries, assessing the risk of disease and applying the most appropriate preventive regimens and recall frequencies based on the individual patients needs and demands.

- National Oral Health Council composed of tribal and IHS clinical dental staff has been formed and have an approved charter. This group will provide a field perspective to issues facing the dental program.

- The Division of Oral Health has completed the oral health status and treatment needs survey of approximately 13,000 patients. A report will be completed in spring 2001 with the final analysis and program recommendations. Tribal and field input was solicited for the report.

- The IHS, National Institutes of Dental and Craniofacial Research, and State University of New York at Buffalo continue to collaborate on the treatment of periodontal disease in persons with diabetes. The initial clinical trial conducted in the Phoenix Area demonstrated the effectiveness of a non-surgical treatment regimen. The project is currently being replicated in the Albuquerque Area. Three 5-year grants were awarded in FY 1998 and three awards will be made in FY 2001 to help IHS, tribal, and urban programs incorporate this technology into their dental programs.

- The Division of Oral Health has developed a process for awarding resources to tribes and Areas to help build the public health infrastructure and capacity through dental clinical and preventive support centers. In FY 2000, four tribal programs were awarded resources to demonstrate unique strategies to provide training and technical assistance to programs within their geographic areas. In FY 2001, up to three additional tribal/Area programs will be awarded.

- The Division of Oral Health continues its efforts to support tribal community water fluoridation programs. In its second year of a three-year inter-agency agreement with the Centers for Disease Control and Prevention (CDC), strategies are being developed to support small water systems to effectively maintain optimal levels of fluoride in their water in order to assure the dental benefits. The Albuquerque and Phoenix Areas are part of the demonstration and have shown a 38 percent increase in water fluoridation compliance from FY 99 to FY 2000.

- Strategies to recruit and retain more dentists in the IHS have been implemented to include an interactive website, promoting civil service Title 38 for dentists, and an expansion of program dollars for loan

repayment. The vacancy rate has declined from 25 percent to 22 percent during the past fiscal year.

PERFORMANCE MEASURES

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At the FY 2002 funding level, IHS would be able to achieve the following:

Indicator 11: During FY 2002, increase the proportion of compliant water utilities serving AI/AN people with optimally fluoridated water by 10 percent over the FY 2001 levels for all IHS Areas.

Indicator 12: During FY 2002, increase the proportion of the AI/AN population who obtain access to dental services by 1 percent over the FY 2001 level.

Indicator 13: During FY 2002, increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth by 1 percent over the FY 2001 level.

Indicator 14: During FY 2002, increase the proportion of the AI/AN population diagnosed with diabetes that obtains access to dental services by 2 percent over the FY 2001 level.

Indicator 15: During FY 2002, reduce the rate of untreated dental decay in children 6-8 year and 14-15 year by 2 percent from the level documented in the IHS 1999-2000 oral health survey.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$65,517,000	861	
1998	$65,517,000	818	
1999	$71,400,000	763	
2000	$80,062,000	745	
2001	$91,018,000	763	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $95,305,000 and 781 FTE is an increase of $4,287,000 and 18 FTE over the FY 2001 enacted level of $91,018,000 and 763 FTE. The increases are as follows:

Built-in Increases: +$2,842,000

The request of $397,000 for inflation/tribal pay cost and $2,445,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indian and Alaska Natives. Maintaining the current

I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$1,445,000 and 18 FTE

The request of $1,445,000 and 18 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	Dollars	FTE
Parker, AZ Health Center	$1,445,000	18